HEALTH CARE REFORM REVIEW COMMITTEE

The Health Care Reform Review Committee was assigned three studies.

Section 15 of House Bill No. 1012 (2013) directed the committee to study the immediate needs and challenges of the North Dakota health care delivery system, implementing the Healthy North Dakota initiative, examining Medicaid reform, and the feasibility of developing a plan for a private health care model that will comply with federal health care reform in a manner that will provide high-quality, accessible, and affordable care for North Dakota citizens.

Section 1 of House Bill No. 1034 (2013) directed the committee to study health care reform options, including the implementation of the Affordable Care Act (ACA) if the federal law remains in effect and state alternatives for state-based health care reform if the federal law is repealed.

Section 3 of House Bill No. 1362 (2013) directed the committee to study the effects of the ACA due to the dramatically changing health care system in the state, including alternatives to the ACA and the Medicaid expansion provisions to make health care more accessible and affordable to the citizens of the state, including access, the cost of providing services, the Medicare penalty to the state's providers, and the Medicaid payment system.

Committee members were George J. Keiser (Chairman), Rick Becker, Alan Fehr, Robert Frantsvog, Eliot Glassheim, Kathy Hogan, Nancy Johnson, Jim Kasper, Alex Looysen, and Karen M. Rohr and Senators Tyler Axness, Spencer Berry, Oley Larsen, Judy Lee, Tim Mathern, and Dave Oehlke.

BACKGROUND

Affordable Care Act

In March 2010 the President signed into law two pieces of legislation that initiated a multiyear effort to implement health care reform in the United States--the Patient Protection and Affordable Care Act (HR 3590) and the Health Care and Education Reconciliation Act of 2010 (HR 4872)--which together are referred to as the Affordable Care Act or ACA. The ACA had stated objectives of creating new structural models to increase access and affordability of health care coverage, reforming operational governance of the health insurance industry, providing consumers protection, and providing new tools for the improvement of the health care delivery system and patient outcomes.

Since enactment of the ACA, North Dakota has made several decisions regarding implementation, including whether to administer the health benefit exchange, whether to select the state's essential health benefits or instead allow the essential health benefits to be selected through the default method, and whether to participate in Medicaid Expansion. The state may have to decide whether to submit an application for a Section 1332 State Innovation Waiver (innovation waiver) to allow the state more flexibility in meeting the requirements of the ACA.

Health Benefit Exchanges

During the November 2011 special session, the Legislative Assembly did not enact legislation to provide for a state-administered health benefit exchange or to allow for state participation in a federally administered health benefit exchange. As a result the state is allowing the federal government to administer its health benefit exchange. The federally administered health benefit exchange is referred to as the federally facilitated marketplace (FFM). Guidelines issued by the United States Department of Health and Human Services (HHS) provide that states will be allowed to transition from one exchange model to another. A state may alter its exchange model in 2015 by submitting an exchange blueprint by November 18, 2013; and for 2016, the blueprint would need to be submitted by November 18, 2014.

Essential Health Benefits

Starting January 1, 2014, the ACA requires individual and small group plans to include all essential health benefits (EHBs), limit consumers' out-of-pocket costs, and meet the Bronze, Silver, Gold, and Platinum coverage level standards. However, grandfathered and self-insured plans are exempt. Large group plans are required to meet the cost-sharing limits and the benefit levels, but are not required to provide the full scope of benefits in the essential benefits package.

The HHS issued a bulletin providing that each state may choose a benchmark plan from one of the following four benchmark plan types:

1. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
2. Any of the largest three state employee health benefit plans by enrollment;

3. Any of the largest three national Federal Employees Health Benefits Plan (FEHBP) options by enrollment; or
4. The largest insured commercial non-Medicaid health maintenance organization (HMO) operating in the state.

In addition to the services covered by the state's selected benchmark plan, the state's essential health benefits must include the following 10 categories of services:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

If a state failed to choose a benchmark plan by September 30, 2012, the default plan would be the nongrandfathered small group plan with the largest enrollment in the state, which in North Dakota at the time was the Medica Choice Passport plan. On September 28, 2012, the Insurance Commissioner submitted a selection of an essential health benefit benchmark plan to HHS, designating the Sanford Health Plan, which at the time was the largest insured commercial non-Medicaid HMO operating in the state.

The HHS has indicated this benchmark plan will apply in 2014 and 2015 and that this overall approach may be changed in 2016 and in future years based on evaluation and feedback.

Medicaid Expansion

As enacted, the ACA required all states to expand Medicaid coverage to eligible state residents with incomes below 138 percent of the federal poverty level (FPL). Failure to comply with this Medicaid expansion requirement would result in penalties. However, the June 28, 2012, ruling of the United States Supreme Court in *NFIB v. Sebelius*, found the ACA's Medicaid Expansion provision is unconstitutionally coercive on states and that this situation is remedied by limiting HHS's enforcement authority. The practical effect of the ruling is that states have the option of expanding Medicaid under the ACA. A state that does not expand Medicaid is not subject to penalties under the ACA.

Section 1 of 2013 House Bill No. 1362 directs the Department of Human Services (DHS) to expand the state's Medicaid program coverage as authorized under the ACA. The department is directed to implement the expansion by bidding through private carriers or utilizing the health benefit exchange. Section 1 of the bill has an expiration date of August 1, 2017.

Section 1332 State Innovation Waivers

Section 1332 of the ACA authorizes states to submit applications for innovation waivers. In March 2011, HHS issued proposed rules implementing the innovation waiver provision of the ACA, and in February 2012 HHS issued final rules, providing that beginning in 2017 a state may qualify for an innovation waiver to allow the state to pursue its own innovative strategies to ensure residents have access to high-quality affordable health insurance. To qualify for an innovation waiver, the state's plan must provide affordable insurance coverage to at least as many residents as the ACA and may not increase the federal deficit.

Healthy North Dakota Initiative

Governor John Hoeven launched the Healthy North Dakota initiative in 2002. The initiative has evolved into a statewide partnership of stakeholders to identify common strategies to address health issues. Through this initiative health priority areas have been identified and coalitions, committees, and focus groups have formed around each of the priority areas, including the Aging Alliance, Coordinated School Health Core Team, North Dakota Diabetes Coalition, Healthy North Dakota Breastfeeding Committee, Healthy North Dakota Early Childhood Alliance, Healthy North Dakota Health Disparities Committee, Healthy North Dakota Healthy Eating and Physical Activity Partnership, Healthy North Dakota Workplace Wellness Committee, Immunizations Committee, North Dakota Cancer Coalition, North Dakota Injury Prevention Coalition, and North Dakota Oral Health Coalition.

Medicaid Waivers

The federal government provides four primary types of waivers and demonstration projects to allow states to test new or existing ways to deliver and pay for health care services through Medicaid and the children's health insurance program (CHIP).

1. Section 1115 research and demonstration projects - Allows states to apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP. Typically, Section 1115 demonstrations are approved for a five-year period and may be renewed for an additional three years. Demonstrations must be budget-neutral to the federal government so during the course of the project federal Medicaid expenditures will not be more than federal spending without the waiver.
2. Section 1915(b) managed care waivers - Allows states to apply for waivers to provide services through managed care delivery systems or otherwise limit a person's choice of providers. Within this waiver, there are four options:
    a. Section 1915(b)(1) allows an applicant to implement a managed care delivery system that restricts the types of providers people may use to get benefits;
    b. Section 1915(b)(2) allows a county or local government to act as a choice counselor or enrollment broker to help people pick a managed care plan;
    c. Section 1915(b)(3) allows the use of savings the state gets from a managed care delivery system to provide additional services; and
    d. Section 1915(b)(4) allows a state to restrict the number or type of providers that may provide specific services, such as disease management or transportation.
3. Section 1915(c) home and community-based services waivers - Allows states to apply for waivers to provide long-term care services in home and community settings rather than in institutional settings.
4. Concurrent Sections 1915(b) and 1915(c) waivers - Allow states to apply to simultaneously implement two types of waivers to provide a continuum of services to elderly people with disabilities.

Legislative Interim Background

2011-12 Interim Health Care Reform Review Committee

During the 2011-12 interim, the interim Health Care Reform Review Committee was assigned the following three studies:

1. Monitor the impact of the ACA, rules adopted by federal agencies as a result of that legislation, and any amendments to that legislation. The committee was directed to report to the Legislative Management before a special session of the Legislative Assembly.
2. Study the impact of the ACA on the Comprehensive Health Association of North Dakota (CHAND).
3. Study the feasibility and desirability of developing a state plan that provides North Dakota citizens access to affordable coverage for health care.

In addition to the three studies, the 2011-12 interim Health Care Reform Review Committee was charged with receiving updates from the:

1. Insurance Commissioner regarding administration and enforcement of the ACA, proposed legislation for consideration at a special legislative session, and proposed legislation by October 15, 2012, for the 2013 regular session;
2. Insurance Commissioner and DHS on planning and implementing a health benefit exchange for the state and proposed legislation for consideration at a special legislative session, or proposed legislation by October 15, 2012, for the 2013 regular session; and
3. Insurance Commissioner with respect to steps taken to ensure health insurer procedures are in compliance with the ACA, proposed legislation for consideration at a special legislative session if the Commissioner is required by federal law to implement any requirement before January 1, 2013, and proposed legislation by October 15, 2012, for any requirement that must be implemented between January 1, 2013, and January 1, 2014.

The committee held six meetings before the November 2011 special session, with a primary focus of determining what actions the state should take to address the health benefit exchange requirement under the ACA and reviewing additional information regarding other elements of the ACA, such as Medicaid Expansion and external review requirements. The committee recommended three bills for the special session.

1. House Bill No. 1474 (2011) would have provided for a state-administered health benefit exchange. This bill failed in the House.
2. House Bill No. 1475 (2011) provided an appropriation of federal funds received by DHS for ACA-related costs of DHS and the Information Technology Department (ITD) relating to incorporating the Medicaid and CHIP eligibility determination functionality into the health benefit exchange and for the purpose of defraying the corresponding costs related to the modification of the DHS economic assistance eligibility system, including 1 full-time equivalent (FTE) position for DHS and 10 FTE positions for ITD; an appropriation from the general fund and federal funds to DHS for the purpose of defraying the expenses of implementation of the ACA's Medicaid Expansion provisions, including 7 FTE positions for DHS; and an appropriation of special funds to the Insurance Commissioner for the purpose of defraying the expenses of implementation of the ACA, including 4 FTE positions. This bill passed as introduced.
3. House Bill No. 1476 (2011) amended the law relating to the external review procedures required for health insurance policies. This bill passed as amended.

Following the special session, the committee held additional meetings and the committee continued receiving regular status reports from the Insurance Commissioner and representatives of the Insurance Department regarding the federal grants that were available to states to assist in implementation of the health benefit exchanges and the status of other states' implementation of health benefit exchanges, the essential health benefits requirements under the ACA, and the state's external review procedure. Additionally, the committee received reports on activities in the state relevant to the committee's study of the state's health care delivery plan and reviewed the June 28, 2012, ruling of the United States Supreme Court in *NFIB v. Sebelius*, regarding the constitutionality of the ACA. The committee recommended House Bill No. 1034 (2013) to provide for a Legislative Management study of health care reform options, which passed and was assigned to the Health Care Reform Review Committee.

TESTIMONY

The committee organized its meetings to address all elements of its three study charges because of the commonality of issues involved in studying implementation of the ACA and North Dakota's health care delivery system.

Implementation of the Affordable Care Act

Department of Human Services Technology

Throughout the interim the committee received reports on the status of DHS modernization of its eligibility determination system and the status of the Medicaid management information system (MMIS). Because the eligibility determination system and enrollment system were not operational in time for ACA open enrollment, DHS exercised its contingency plan while the technology projects continue to be developed. The DHS awarded a contract to a vendor to operate a call center and to perform eligibility application processing.

Medicaid Expansion

Throughout the interim the committee received reports on the status of implementation of Medicaid Expansion, including the creation of the request for proposal (RFP), the bidding process, vendor selection, enrollment, and issues that arose throughout the implementation process.

In accordance with House Bill No. 1362 (2013) DHS sought a private carrier through which the state would provide Medicaid Expansion via a managed care program. The initial plan was for DHS to select two vendors. However, of the two private carriers that submitted bids and were offered contracts under the RFP, only one accepted the contract. Sanford Health Plan entered a contract with the state to provide insurance coverage for the state's Medicaid Expansion population.

The committee received information regarding the Sanford Health Plan network in the state and how Sanford Health Plan meets the Medicaid Expansion access requirements. To meet the necessary network requirements, Sanford Health Plan worked with public health units to establish in-network provider contracts. The following public health units enrolled as in-network providers:

- Central Valley Health District (Stutsman and Logan Counties);
- Custer Health (Morton and Logan Counties);
- Dickey County Health District;
- Fargo Cass Public Health;
- LaMoure County Health Department;
- Ransom County Public Health; and
- Walsh County Health District.

In addition, a representative of Sanford Health Plan reported efforts are being taken to establish contracts with the eight regional human service centers and to credential the providers within the human service centers.

The committee received testimony from pharmacists and a representative of the North Dakota Pharmacists Association that Medicaid Expansion is being administered in a manner that is unfair and unreasonable to many pharmacists in the state. Pharmacist concerns included lack of willingness to negotiate contracts with a "take-it-or-leave-it" approach to negotiation, being automatically rolled into a network without knowing it was going to be used to serve the Medicaid Expansion population, not being offered a contract to participate in serving Medicaid Expansion patients, being unable to opt out of serving Medicaid Expansion patients unless the pharmacist also drops out of the existing contract, and being offered reimbursement that does not cover the cost of doing business.

Although contracts and antitrust laws prohibited the pharmacists from discussing the specific Medicaid Expansion pharmacy reimbursement rates, the committee received testimony that the reimbursement rates under Medicaid Expansion are significantly lower than the commercial Sanford Health Plan rates and the Medicaid Expansion contract is under a different contracted network. The testimony attributed most of these issues to the fact that Sanford Health Plan contracts with the pharmacy benefits manager Express Scripts.

Pharmacists testified in support of transparency, including publication of a pharmacy fee schedule with a single set of terms and conditions for providers of Medicaid Expansion, similar to how Medicaid and Workforce Safety and Insurance do business; in support of reimbursement rates being adequate to cover the pharmacist's cost of doing business; and in support of allowing pharmacists to opt out of serving Medicaid Expansion patients.

In response to these pharmacy reimbursement issues, a group of stakeholders worked to try to resolve the issues. A representative of Sanford Health Plan testified effective August 1, 2014, Sanford Health Plan would adopt a broad network specifically for Medicaid Expansion and effective September 1, 2014, would pay sole community providers an enhanced dispensing fee. A representative of DHS testified although the pharmacy reimbursement rates for 2015 have not yet been set, the rates will be increased from the 2014 rates and there will be increased transparency.

The committee learned the Medicaid Expansion enrollment numbers have increased by approximately 1,000 enrollees per month, and this increase is expected to continue until the enrollment nears 20,000 by the end of the 2013-15 biennium.

With Medicaid Expansion, approximately 784 CHIP-enrolled children will move to Medicaid Expansion. Originally this transition from CHIP to Medicaid Expansion was expected to take place January 1, 2014. However, the state was authorized to make these transitions from CHIP to Medicaid Expansion as the CHIP renewal dates arise. Additionally, due to changes in Medicaid eligibility disregards and deductions, some children previously eligible and receiving Medicaid will not be eligible under this new formula. Approximately 3,100 children who are no longer eligible for Medicaid will be allowed to transfer to CHIP for one year. In the case of adults who are found ineligible for Medicaid due to these new eligibility standards, the adults will receive a six-month period of continued eligibility.

A representative of DHS testified that prior to ACA open enrollment, DHS elected to be what is referred to as an assessment state for applications made through the FFM. In an assessment model, the FFM does not make a final eligibility determination, but instead the FFM transmits the account to the state once the FFM has evaluated the individual and identified the applicant as Medicaid or CHIP eligible, and then the state makes the formal determination.

As of July 1, 2014, North Dakota became a determination state. In a determination model the state accepts the eligibility determinations made by the FFM. In both an assessment and determination model the FFM utilizes the same set of eligibility criteria. By choosing the determination model the state must now accept the FFM determination as final. The determination remains in place until the next period of redetermination takes place or until a change occurs in the client's circumstances. This change should alleviate some of the pressure on state and local resources required to process applications.

Medicaid Expansion Estate Recovery

North Dakota's Medicaid estate recovery law applies to individuals who are eligible for Medicaid Expansion under the modified adjusted gross income (MAGI) eligibility rules. The Centers for Medicare and Medicaid Services (CMS) has noted in a guidance letter that it "intends to thoroughly explore options and to use any available authorities to eliminate recovery of Medicaid benefits consisting of items or services other than long-term care and related services in the case of individuals who are determined eligible for Medicaid benefits under the MAGI methodology."

A representative of DHS testified North Dakota could amend its estate recovery statutes to provide this same result. The amendments would only apply to estates for which the death occurred after the effective date of the amendments. Due to the lack of asset information available for the Medicaid Expansion recipients whose eligibility was determined

under MAGI eligibility rules, it will be difficult to identify the expected estate recoveries from this population. Any exemption from estate recovery for Medicaid Expansion recipients would decrease future estate recoveries. It is possible there will be legislation introduced in 2015 to address this issue.

Medicaid Expansion and Medicaid Cost-Sharing

The committee received an overview of what federal Medicaid rules allow for cost-sharing and out-of-pocket costs. States can impose copayments, coinsurance, deductibles, and other similar charges on most Medicaid-covered benefits and the amounts that can be charged vary with income. For Medicaid enrollees with income at or below 100 percent of FPL, cost-sharing for most services is limited to nominal or minimal amounts. States have options to establish alternative out-of-pocket costs which may target certain groups of Medicaid enrollees with income above 100 percent of the FPL. Out-of-pocket costs may be higher than nominal charges depending on the type of service and cannot exceed 5 percent of the family income.

Michigan obtained approval from CMS to amend its Section 1115 Medicaid Demonstration Waiver, "Healthy Michigan," to implement Medicaid Expansion that includes an alternative cost-sharing plan for enrollees. The committee received a general comparison between North Dakota's and Michigan's Medicaid Expansion programs and a summary of North Dakota's current Medicaid copayment amounts. A representative of DHS testified North Dakota's Medicaid copayment amounts have been considered nominal and therefore it is not necessary to track household income. Limitations in DHS's current information technology system limit the ability of DHS to track the income data necessary to track in order to impose higher copayment amounts.

Coverage for Substance Abuse Treatment

Representatives of the substance abuse treatment community brought to the attention of the committee several concerns regarding changes taking place in the state which negatively impact substance abuse treatment, including:

1. Concern whether Medicaid Expansion will adequately provide substance abuse services and whether the network of providers will be adequate.
2. Concern the state's EHB benchmark plan provides for less comprehensive substance abuse coverage than many pre-ACA plans, and as a result, all health insurance plans in the state are significantly cutting benefits in all plans to match this benchmark coverage.
3. The mental health and addiction services provider network will be stretched due to more people being insured under the ACA and Medicaid Expansion and due to population growth in rural areas resulting from oil development.

A representative of the Insurance Department testified that in comparing the EHB benchmark plans, the Blue Cross Blue Shield of North Dakota (BCBSND) plans had the richest coverage for addiction services. Current reports from the federal government indicate 2016 will be the first opportunity for states to change their EHB selection. Until 2016, if a state changes its EHB, the state may be financially liable for costs associated with increasing the state's EHB.

Other factors surrounding the issue of substance abuse coverage include an outstanding request for an Attorney General opinion on the issue of interpreting the state and federal mandates for substance abuse coverage, the Insurance Department has an ongoing market conduct examination being conducted which addresses the issue of substance abuse coverage, the federal Mental Health Parity and Addiction Equity Act of 2008 rules became effective July 1, 2014, and will be recognized as plans are renewed, and the interim Human Services Committee was charged with studying behavioral health needs and that committee was addressing some of the elements related to these concerns.

A representative of Sanford Health Plan testified that effective July 1, 2014, with the exception of grandfathered plans and small group plans, all health insurance plans are required to provide parity between physical health coverage and mental health and substance abuse treatment coverage. As part of this federal law, the definition of what qualifies as residential treatment has been clearly defined. The bottom line is that insurance policies will be required to cover residential treatment. Additionally, effective January 1, 2015, Medicaid Expansion will include coverage of residential treatment for mental health and substance abuse treatment.

As part of the committee discussion regarding EHB and substance abuse treatment, the committee received a report on the activities of the interim Human Services Committee and the activities and recommendations of the Behavioral Health Stakeholders Group.

Insurance Department - Rate Filing

A representative of the Insurance Department testified the department abides by the following in performing rate review and form review for health insurance policies:

1. Rate review:
    a. For products offered outside the FFM only, the Insurance Department will perform the rate review.
    b. For products offered inside and outside the FFM, the Insurance Department will perform its review based on the outside plan filing and submit that approval through the system for electronic rate and form filing (SERFF).
    c. For products offered inside the FFM only, the Insurance Department will not perform rate review.
2. Form review:
    a. For projects offered outside the FFM only, the Insurance Department will perform the review, including review for state and federal requirements.
    b. For products offered inside and outside the FFM, the Insurance Department will accept a checklist attestation for federal reforms and review the filings for compliance with North Dakota statutory and regulatory requirements.
    c. For products offered inside the FFM only, the Insurance Department will accept a checklist attestation for federal reforms and review all North Dakota statutory and regulatory requirements.

Discontinuation of Health Insurance Policies

When the ACA was passed, a statement was made "if you like your plan, you can keep it." However, as implemented, consumers were informed some individual and group policies did not meet the necessary requirements of the ACA, and those policies would be discontinued. However, in response to the negative response to this policy, the federal government allowed states to decide whether to let these policies continue as transitional policies for another year--this period of time was later extended to two years. In North Dakota, the Insurance Commissioner left it to the insurance companies to decide whether to continue these policies as transitional policies.

- BCBSND declined to continue both its group and individual policies, and reported approximately 31,600 members received discontinuation notices--which is equal to approximately 8 percent of the 400,000 North Dakotans served by BCBSND;
- Medica declined to allow transitional plans in the group market, but did offer transitional plans in the individual market. Approximately 3,173 members in the individual market were allowed to stay in their transitional plans.
- Sanford Health Plan allowed transitional plans in both the group and individual markets. In the individual market, approximately 540 members were allowed to stay in their transitional plans, and in the group market, approximately 1,823 members were allowed to stay in their transitional plans.

Federally Facilitated Marketplace Enrollment

Through the course of the interim the committee received updates from the Insurance Commissioner, representatives of the Insurance Department, and representatives of insurers on the status of enrollment under the FFM, including enrollment figures. The 2014 open enrollment period was October 1, 2013, through March 31, 2014. The 2015 open enrollment will run November 15, 2014, through February 15, 2015. In 2014 the tax penalty for not having health insurance is the greater of $95 or 1 percent of yearly household taxable income. In 2015 the tax penalty will be the greater of $325 or 2 percent of income.

The committee received information regarding the 2015 reenrollment process. Under the reenrollment process recently announced by the federal government, policyholders in the FFM who receive subsidies will receive up to three notices from the FFM informing them how to update their information for the next year. Policyholders will also receive a notice from their insurance carriers outlining new premium rates, the amount they are eligible to save on their monthly premium through tax credits and cost-sharing reductions, and the ability to switch plans if they choose. Representatives of the Insurance Department and insurers voiced concern that these multiple notices may be confusing to customers.

Other States

Throughout the committee's study and review of implementation of the ACA, the committee received information regarding how other states have addressed similar matters and references to receipt of information regarding other states are included throughout in this report. However, the committee did receive a computer presentation from a representative of the Blue Cross Blue Shield Association which specifically provided a high-level overview of the ACA--past, present, and future. The presentation included information regarding:

- How other states have fared in implementing the ACA, including enrollment;
- State successes and failures in accomplishing the goals of the ACA;

- Partisan perception of the ACA;
- Leading reasons why the uninsured have not purchased health care;
- Challenges to health insurance affordability, such as rising prices of medical services, increased utilization of services, a delivery system that rewards volume, taxes and fees, and how uncertainty effects affordability;
- How rate stabilization protects consumers;
- The objectives for, explanation of, and funding for risk adjustment, reinsurance, and risk corridors; and
- Identifying practical realities, such as allowing the market time to adjust and considering whether regulation is leveling the playing field, impeding innovation, or limiting choice.

The committee received testimony that although all of the state-administered health benefit exchanges are experiencing challenges, Kentucky and Connecticut have state-administered exchanges that are doing well, as are the state-administered exchanges in California, New York, and Rhode Island. However, it was reported Oregon's state-administered exchange is experiencing significant problems. Almost universally, one of the biggest challenges being faced by state-administered exchanges is how best to mesh the new exchanges with the existing Medicaid information technology systems. There was a general underestimation of the information technology complexity related to creating and administering these exchanges. The single most important factor in determining whether a state would be successful in creating and administering a state-administered exchange is whether that state set reasonable expectations. In the case of Kentucky and Connecticut, they stuck to the basics when creating the plan, with the expectation they would build additional features into the exchanges over time. The states that have struggled seem to have taken on too much all at one time.

Generally, Medicaid Expansion enrollment through the exchanges is meeting the states' expectations. However, as it relates to Medicaid Expansion, the states have experienced some administrative, operational, and governance challenges. Some of these problems are resulting because the state agencies that administer the Medicaid Expansion programs are not very familiar with the private insurance market.

Insurer Panel Discussions

The committee held multiple panel discussions of insurers and received a broad range of timely information regarding ACA implementation. Topics addressed over the course of the interim include:

- Grandfather status plans;
- Provisions of the ACA unique to members of federally recognized Indian tribes;
- Tobacco use as a rating factor;
- The small business health options program (SHOP);
- How premium subsidies work;
- Employer requirements;
- Health care cost drivers and how to mitigate these cost drivers;
- Challenges related to data transfer under the FFM;
- Emerging trends in health care costs;
- How social changes and education related to the ACA may impact future enrollment;
- Steps insurers are taking to increase use of agents;
- Special enrollment periods and verification of qualifying events;
- Nonpayment, delinquency, and termination of policies; and
- Reenrollment processes and notices.

Employers

The committee received information regarding the choices faced by a North Dakota small business when selecting a group health insurance plan. The information compared and contrasted the business's existing grandfathered health plan to a comparable metallic plan under the ACA.

- The grandfathered plan experienced a 22 percent increase in premium from last year to the current year of which the insurer attributed 2 to 2.25 percent to the ACA;

- Under the metallic plan, larger families and tobacco users experienced a large increase in premium; and
- As it relates to experience, there are winners and losers under both plans.

The committee received information presented by a representative of Eide Bailly LLP regarding ACA implementation issues being faced by employers, including penalties large employers will face if the employers do not offer employees affordable health insurance, employer reporting requirements, and excise taxes for "Cadillac" health plans.

CHAND

The committee received an update on status of the CHAND plan, how the plan has been impacted by the ACA, and whether the implementation of the ACA will necessitate any changes to the CHAND program.

The committee received an overview of the multiple ways an applicant may qualify for health insurance coverage through the CHAND program. The implementation of the ACA has effectively eliminated new enrollment in the traditional CHAND plans that are designed to cover applicants who are denied traditional health insurance coverage. Additionally, Medicaid Expansion has attracted a handful of CHAND subscribers. However, CHAND has already received requests to return to the program, primarily due to provider network restrictions. Overall, with the implementation of the ACA, CHAND has realized a small drop in enrollment.

The committee received testimony in support of retaining the CHAND program. With the implementation of the ACA, several states discontinued their high-risk pools. However, some of these states are now trying to reinstate their high-risk pools.

Public Employees Retirement System Uniform Group Insurance Plan

The committee received a report on the status of the Public Employees Retirement System (PERS) uniform group insurance plan. A representative of BCBSND reported the state should be eligible to retain the plan's grandfathered status under the ACA if the following conditions continue to be met:

- Benefits are not significantly cut or reduced;
- Decreases in employer contribution to premium are limited to reductions of no more than 5 percent below the contribution rate on March 23, 2010;
- Coinsurance percentages are not increased;
- Increases in copayments are not more than the greater of $5 or cumulative medical inflation plus 15 percent based March 23, 2010, rates; and
- Increases in deductible and out-of-pocket maximums are not more than cumulative medical inflation plus 15 percent based on March 23, 2010, rates.

Enrollment Assistance

Throughout the interim the committee received status reports on ACA enrollment assistance services being offered in the state to assist members of the public in enrolling for coverage. In states with FFMs, CMS awarded grants to entities to provide navigator services. The grant awards and recipients for 2013-14 and 2014-15 are:

Recipient	2013-14 Award Amount	2014-15 Award Amount
Great Plains Tribal Chairman's Health Board*	$186,000**	$148,659**
North Dakota Center for Persons with Disabilities	$414,000	$451,342

*Recipient offers navigator services in North Dakota and South Dakota.

**Award amount reflects the portion of the award attributable to services provided in North Dakota.

In addition to the navigator grants awarded by CMS, the Health Services Resources Administration (HRSA) provided funding to community health centers (CHCs) to conduct ACA outreach and education and to provide enrollment assistance through certified application counselors (CACs). Community HealthCare Association of the Dakotas (CHAD) received funding from HRSA and used this funding to provide education and outreach and for hiring CACs.

Besides the different funding sources, the primary differences between navigators and CACs include navigators conduct outreach, education, and one-on-one assistance and CACs do not provide the outreach and education services and navigators receive more training than CACs. In addition to navigators and CACs, agents and brokers are able to complete certification to qualify to participate in the FFM. The Insurance Department website includes a list of certified North Dakota agents and brokers.

Quality Improvement

The committee received a presentation from a representative of North Dakota Health Care Review, Inc., on the past, current, and future status of health care quality improvement efforts in the state. North Dakota Health Care Review, Inc., is the CMS-designated Medicare quality improvement organization for North Dakota.

The committee learned that in 2004-05, the federal Medicare Modernization Act and Deficit Reduction Act initiated quality data reporting for hospitals, pay for performance reporting, transparency through Hospital Compare, and development of pay-for-performance strategy. In 2009 the ACA added to these efforts by including a continued focus on improving quality and safety, transparency, and partnership for patients, and value-based purchasing for hospitals, hospice, acute long-term care hospitals, rehabilitation hospitals, and others.

The committee received an overview of the hospital value-based purchasing program (VBP). The VBP is a Medicare payment strategy that rewards quality versus volume alone. The current VBP impacts six prospective payment system (PPS) acute care hospitals in North Dakota. The program is required to be budget-neutral and is funded by a 1 percent withholding from PPS hospital diagnosis-related group (DRG) payments. Under VBP, hospitals are evaluated on two domains--clinical processes (70 percent of the score) and patient experience (30 percent of the score). If a hospital performs better than the national average it will earn back all of the 1 percent withholding and more, and if the hospital performs under the national average it will earn back less than the 1 percent withholding. The withholding portion increases incrementally each year to 2 percent by 2017.

The committee received an overview of the hospital readmission reduction program. The program began with fiscal year 2012 PPS hospital discharges. The hospital's score is based on risk-adjusted, 30-day readmission rates for acute myocardial infarction, heart failure, and pneumonia. Hospitals lose a portion of DRG base payment for risk-adjusted rates higher than the national average--1 percent in 2013 and 2 percent in 2014. In 2015 added conditions will include chronic obstructive pulmonary disease and hip and knee surgeries.

The committee received an overview of the ACA reporting, transparency, and VBP programs and how these programs are or will be affecting critical access hospitals, nursing homes, physicians, home health, hospice, acute long-term care hospitals, rehabilitation hospitals, and others. The committee received an overview of ongoing quality improvement and safety initiatives that encourage improvement and help prepare providers for the VBP programs.

Section 1332 Waiver for State Innovation

The committee received a presentation from a representative of the National Association of Insurance Commissioners (NAIC) regarding the ACA's Section 1332 Waiver for State Innovation. The committee reviewed what ACA provisions the innovation waiver allows states to waive. The list of provisions a state may waive contains most of the legislation's major building blocks--exchanges, mandates, and subsidies--and therefore creates an opportunity for states to radically reshape the ACA's structure. However, there are important limitations that must also be noted. None of the ACA's amendments to the federal Public Health Service Act (PHSA), which contain the vast majority of new standards that now apply to new health insurance coverage, may be waived under an innovation waiver. Consequently, all newly sold health insurance coverage will still have to comply with these provisions.

To qualify for an innovation waiver a state must demonstrate its proposal will meet four requirements:

1. Coverage will be at least as comprehensive as the EHBs (the "comprehensive coverage requirement");
2. Coverage and cost-sharing protections against excessive out-of-pocket spending will be at least as affordable as the provisions of Title I of the ACA (the "affordability requirement");
3. The plan will cover at least a comparable number of residents as Title I of the ACA (the "scope of coverage requirement"); and
4. The plan will not increase the federal deficit (the "federal deficit requirement").

States will be required to submit extensive supporting documentation that innovation waiver proposals will meet these requirements, including actuarial analyses and certifications, data, and assumptions that will allow the appropriate federal agencies to determine whether a state's plan will meet these requirements. Additionally, state plans must be certified by the Office of the Actuary at CMS as providing coverage that will be at least as comprehensive as the EHBs based upon data from the state and other comparable states.

A complete application must include the following:

- A comprehensive description of the state legislation and program to implement the plan;
- A copy of enacted state legislation authorizing the innovation waiver request (if a state already has a law in place allowing the plan to be implemented new legislation is not necessary);

- A list of provisions of the ACA that the state seeks to waive, with the reason for each specific request, analyses, actuarial certifications, data, assumptions, analysis, targets, and other supporting information:

  Actuarial analyses and certifications to demonstrate compliance with the comprehensive coverage, affordability, and scope of coverage requirements;

  Economic analyses to demonstrate compliance with the four coverage requirements;

  A detailed 10-year budget plan that is deficit-neutral to the federal government, considering all costs, including administrative costs, to the federal government;

  A detailed analysis regarding the estimated impact of the innovation waiver on health insurance coverage in the state; and

  Data and assumptions used to demonstrate compliance with requirements for innovation waivers;

- A detailed draft timeline for the state's implementation of the proposed innovation waiver;

- Explanations of:

  Whether the innovation waiver increases or decreases administrative burdens on individuals, insurers, and employers;

  How the innovation waiver will affect implementation of other provisions of the ACA in the state;

  How the innovation waiver will affect residents seeking health care services out of state;

  How the state will provide the federal government with all information necessary to administer the innovation waiver at the federal level; and

  How the proposal will address potential compliance, waste, fraud, and abuse committed by individuals, employers, insurers, or health care providers;

- Quarterly, annual, and cumulative targets for the comprehensive coverage, affordability, scope of coverage, and federal deficit requirements; and

- Written evidence the state has provided public notice and a meaningful opportunity to comment, including through public hearings convened by the state and separate consultations with federally recognized Indian tribes within the state's borders, as well as a summary of major issues raised by commenters.

The federal government will perform periodic reviews of the implementation of any approved innovation waivers and states must hold a public forum within six months of the implementation date of an innovation waiver, followed by annual forums thereafter. In addition, states will be required to submit quarterly reports detailing any ongoing operational challenges associated with innovation waiver implementation, any plans to overcome those challenges, and the outcomes of those actions. Annual reports must be submitted to the federal agencies each year document progress of the innovation waiver implementation process; compliance with the comprehensive coverage, affordability, scope of coverage, and federal deficit requirements; a summary of the annual public forum and all comments received at that forum; and any other information required under the terms and conditions of the state's approved innovation waiver.

The Chairman made repeated attempts to contact a representative of CMS to discuss the North Dakota's opportunities and possible timelines to apply for an innovation waiver and CMS was unable to provide detailed information.

North Dakota's Health Care Delivery System

Workforce Demographics

As an introduction to the state's demographic data, the committee received a report from a representative of the North Dakota Census Office. The report addressed population projections, population estimates since the 2010 decennial census, changes in age groups and gender balance, migration, select economic statistics, and health insurance data.

Following up on this general demographic data, the committee received a report from a representative of the Labor Market Information Center of Job Service North Dakota of online job openings in the state in health care-related occupations and received a report from a representative of the University of North Dakota School of Medicine and Health Sciences (School of Medicine) on the most recent health care workforce demand assessment.

The committee reviewed the report *2010 Snapshot of North Dakota's Health Care Workforce*, prepared for the School of Medicine, which addresses workforce needs for multiple professions, including dentists, dental hygienists,

chiropractors, optometrists, psychologists, social workers, physical therapy assistants, occupational therapy assistants, dieticians, respiratory therapists, emergency medical technicians, medical and clinical laboratory technologists, medical and clinical laboratory technicians, pharmacists, and pharmacy technicians. The publication reports:

- Several professions have more providers statewide than the national average; however, maldistribution of providers has resulted in many rural counties being without adequate access to health care services. In some cases more providers are needed in North Dakota as compared to the nation due to an aging population and provision of care across rural areas. Programs designed to increase awareness about rural practice for students and graduating providers to increase recruitment along with supportive programs for providers located in the rural areas can help recruit and retain providers in these areas.
- Other providers that have more than the national average are mostly distributed throughout the state with only a few counties with an inadequate supply of providers and low vacancy rates. These professions could be examined more closely to determine what strategies have been utilized to ensure this supply.
- For many health professions, several counties have zero providers. Future studies should examine the regionalization of services, including determining secondary and outreach sites in order to determine where gaps exist at the community level. Once gaps are determined, efforts for network organizations to share providers or services could ensure access to these services. In addition, telehealth could be expanded to provide these services to very rural communities.
- Many professions are dominated by particular gender. To increase the potential workforce and greater provider diversity, efforts should be increased to encourage males and females into the wide array of health care occupations in North Dakota.
- Several professions include many providers who will potentially retire within the next 10 years. Efforts to encourage more providers into these fields, retain them in North Dakota, and provide support throughout their career should be increased. In addition, providers nearing retirement age could become engaged in mentoring, teaching, planning, and other alternative roles which may help retain them in the workforce longer.
- Several professions have salaries that are below the national rate. To increase North Dakota's ability to recruit and retain these providers, mechanisms to potentially increase salaries should be explored, including reimbursement rates and tax incentives.

The committee reviewed the report *Spotlight on the Past and Looking Forward to the Future of Nursing in North Dakota, January 2013*, prepared for the North Dakota Center for Nursing, which recommends:

- K-12 Pipeline - There are currently many programs and activities that target students in K-12 to increase their awareness of health careers and in nursing in particular and interest in nursing careers has been sustained over a number of years. However, about one-fifth of students are undecided about their future careers. This pool of students would benefit from targeted hands-on activities, including high-fidelity human patient simulation and activities to bring a greater awareness of the wide scope of the nursing profession. The North Dakota Center for Nursing is working to link targeted partners to provide these opportunities and resources to students.
- Higher Education - North Dakota has a wide cadre of established nursing programs that utilize clinical sites across many areas. However, 17 counties currently have no clinical sites. These are largely rural counties. The North Dakota Center for Nursing is working to determine clinical placement gaps and to work with nursing programs and employers to facilitate additional clinical placements. Although licensed practical nurse (LPN) programs include about one-fifth minority students, other nursing programs have few minority or male students. Great efforts to increase diversity in nursing education programs are needed. This is also a concern with nursing faculty as there are very few male or minority nursing faculty. The North Dakota Center for Nursing is working to collaborate with several existing grant-funded programs that are targeting increasing diversity. The North Dakota Center for Nursing is also working on developing cultural competence training for faculty. Few current students and nurses are interested in becoming faculty members. In addition, few nurses have climbed the career ladder and obtained further education. Efforts need to be increased to create seamless career ladders among North Dakota's nursing education programs. The North Dakota Center for Nursing is also working to develop faculty recruitment and mentoring programs to help increase the future faculty pool.
- Nursing Supply and Demand - While North Dakota has a good supply of registered nurses and advanced practice registered nurses there is a misdistribution, with some rural areas without an adequate supply of registered nurses. In addition, with the implementation of the ACA it is anticipated that registered nurses will be utilized in greater care coordination roles and advanced practice registered nurses utilized to fill in areas with physician shortages. The North Dakota Center for Nursing is working to provide a career center along with support to health care facilities to increase retention of new graduates across urban and rural settings. North Dakota currently has a good supply of LPNs with some maldistribution. However, projections indicate that the slow growth of LPN supply over the last several years will not be adequate for future projected demand. Efforts

to increase the pool of LPNs and to retain current LPNs are needed. The North Dakota Center for Nursing is working to establish regional LPN interest groups to establish opportunities for education, networking, and support that are currently nonexistent.

The committee reviewed data on advanced practice registered nurses in North Dakota, as well as information regarding recent legislative steps that have been taken to help more fully utilize advanced practice registered nurses within their scope of practice.

Workforce Programs

In addition to receiving data on health care workforce supply and demand, the committee received information regarding existing programs and activities addressing health care workforce needs, including information regarding North Dakota's Area Health Education Center (AHEC) centers with offices located in Mayville, Hettinger, and Beulah. The AHEC centers work closely with the School of Medicine's Center for Rural Health and other statewide partners to address workforce pipeline issues, including:

- Working directly, at no cost, to support and assist with recruitment of primary care and other health professionals to rural health care facilities (short term).
- Improving the number of health profession students who participate in rural community-based learning experiences and increasing the number of rural locations.
- Supporting and retaining the current workforce through programs like the Community Apgar Project, which focuses on identifying challenges and benefits to recruiting and retaining primary care providers to rural communities (short term).
- Rural-collaborative opportunities for occupational learning (R-COOL) health scrubs camps and health academies. The camps are one-day events conducted in rural communities to introduce local students to a variety of health careers through hands-on interactive activities conducted by local health professionals. The academies are on-campus events which target middle school and high school students interested in health careers (long term).

Health Professional Loan Repayment Programs

The state's loan repayment programs are state-financed and state-administered programs designed to attract physicians, nurse practitioners, physician assistants, and dentists to practice in areas of need. The committee received overviews of the following state loan repayment programs:

- State community matching physician loan repayment program (North Dakota Century Code Chapter 43-17.2), created in 1991;
- State medical personnel loan repayment program (Chapter 43-12.2), created in 1993;
- Dentists' loan repayment program (Chapter 43-28.1), created in 2001; and
- Dental nonprofit public health program (Chapter 43-28.1), created in 2009.

The criteria for the programs is not uniform from program to program. The funding amount as well as the funding sources for the state programs also vary from program to program. In addition to the state programs, there are federal loan repayment programs for which graduates may qualify. Again, the criteria for the federal programs differ from the state criteria.

The committee members discussed the importance of evaluating the programs to make sure they are accomplishing the intended goals and that they work well together and with federal programs.

School of Medicine

The committee received reports presented by the Dean of the School of Medicine addressing:

- The current status of provider supply of physicians, psychologists, nurses, pharmacists, pharmacy technicians, physical therapists, and dentists;
- The impact of changing North Dakota demographics on future health care needs;
- The possible impact of implementation of the ACA, using the Massachusetts experience as a model;
- Special health care delivery challenges in North Dakota; and
- What the School of Medicine is doing to meet North Dakota's health care needs.

The committee was informed there is a mild to moderate shortage of primary care providers, general surgeons, pediatricians, OB-GYNs, and especially dentists; there is an adequate number of mental health workers, compared with United States averages; and the largest provider supply challenge in North Dakota is maldistribution of providers, rather than a major shortage.

The combination of an aged and aging population along with population growth means North Dakota's health care workforce needs are going to get much larger. Even as the health care workforce is expanded, particular attention will be needed to ensure an adequate distribution of providers throughout all of North Dakota.

Using the Massachusetts experience as a model, the impact of the ACA may mean better insurance coverage will be achieved, there may be a substantial increase in Medicaid participation, and cost containment may continue to be a challenge.

Special health care delivery challenges in North Dakota were identified as:

- Maldistribution of providers;
- Elderly rural population;
- Geriatric care in general;
- Mental and behavioral health;
- Rural emergency medical services;
- Dental and oral health; and
- Itinerant workers and trauma care issues.

The School of Medicine's Health Care Workforce Initiative has the goals of:

- Reducing disease burden through a master of public health program and by further programming approaches under study to address mental and behavioral health issues in the state;
- Retaining more of our graduates, through pipeline activities, a revised medical school admission process, and a RuralMed program to reduce medical student debt;
- Training more graduates by expanding class sizes--medical student classes increased by 16 students per year, health sciences students increased by 30 students per year, and resident slots increased by 17 residents per year; and
- Improving the efficiency of our health care delivery system by training interprofessional education emphasizing value of clinical teams in care management and a geriatrics training program to help clinicians across the state better manage seniors and their chronic diseases.

The committee received a report of the preliminary School of Medicine's Advisory Council's biennial workforce survey. The final report will be entitled *Third Biennial Report: Health Issues for the State of North Dakota 2015* and will be published December 2014.

Coordinated Care

The committee received an overview of the BCBSND MediQHome program, which is BCBSND's version of a program for a patient-centered medical home or coordinated care model. Blue Cross Blue Shield of North Dakota began the MediQHome pilot project in 2005, expanded the pilot project in 2007, and in 2009 expanded the program statewide. The overview provided included data to help illustrate why BCBSND is pursuing this program.

The components of a medical home model include:

- Team based approach to care - No longer dependent on face-to-face visits for care and revenue and all practice staff have responsibility for care management;
- Care management - Disease registries are used to ensure timely chronic care and preventive services and patients are able to access services with shorter waiting times;
- Care coordination - Care is organized across all elements of the broader health care system; and
- Enabled technology - Using information technology to improve patient care and use of reporting of quality and patient experience measures.

The MediQHome program currently has the following suites:

- Asthma;
- Attention deficit hyperactivity disorder;
- Congestive heart failure;
- Coronary artery disease;
- Diabetes;
- Hypertension;
- Breast cancer screening;
- Colon cancer screening;
- Cervical cancer screening;
- Tobacco use assessment;
- Immunizations; and
- Vitals.

Under the MediQHome program, a physician will spend approximately one-third of the time providing face-to-face care, which may include videoconferencing; one-third of the time making phone visits and email visits; and one-third of the time supporting the care team. As a result of this care model, patients may be cared for via multiple encounter modes, including phone visits, email, and nonphysician team member visits.

Under the MediQHome program, provider reimbursement provides that for each BCBSND member with a chronic disease condition, the provider receives a semi-annual "care management fee" that is based on whether the member has single or multiple chronic conditions. Current barriers to the program include ongoing discussion of whether the care management fee is set at an appropriate rate.

The committee sought to determine whether there may be legislative actions that could be taken to incentivize use of the MediQHome program. The committee considered whether the PERS uniform group plan could be used to increase participation in the MediQHome program and whether the Medicaid program could be incentivized to increase usage of the MediQHome program. The committee was essentially informed that continued growth and success of the program will rely on primary care clinicians embracing the program. In order to support primary care clinicians, a successful patient-centered medical home program should include resources for providers and workforce support. Blue Cross Blue Shield of North Dakota is providing practices with health technology tools and sharing patient data with physicians and their staff, hopefully giving the practitioners the resources they need to improve the care they provide to their entire patient population.

Although BCBSND is the largest commercial insurer in the state, CMS is the largest payor in the state. Due to North Dakota's small size, BCBSND has not been successful in motivating CMS to start pilot projects in the state to increase outcome-based reimbursement instead of fee-for-service reimbursement. It was reported that if the providers can agree on the price and the metrics, the MediQHome program will continue to grow and gain steam.

The committee also received information regarding coordinated care efforts being taken in South Dakota with state employees and Medicaid recipients and coordinated care efforts being taken by DHS.

Preventive Health and Wellness

The committee received testimony from the State Health Officer regarding primary prevention, which is the prevention of risk factors associated with disease and death; secondary prevention, which is identifying a disease process and intervening to prevent further complications or death; and tertiary prevention, which includes rehabilitation or palliation working with people who have complications of disease and preventing or inhibiting further deterioration to the extent possible. The business plan for our current health care system primarily revolves around secondary and tertiary prevention of diseases. The reality is reimbursement for treatment of disease is much greater than providing prevention care in most clinical situations. A major change to the reimbursement formula to encourage effective prevention is part of the answer to improve quality of life and decrease or significantly modify health care costs.

The State Health Officer identified comprehensive worksite wellness and school wellness as realistic and cost-effective ways to increase integration. The State Health Officer suggested the following changes and strategies

should be considered when looking at improvements to the health and wellness system in the United States and in North Dakota:

- Transition from disease to wellness orientation;
- Transition from fee-for-service to outcome reimbursement;
- Increase the number and distribution of primary care clinicians;
- Establish effective medical homes;
- Truly engage communities to own their problems and solutions;
- Enhance the integration of public health and primary care; and
- Improve access of the total population to health care and wellness services.

The committee received data regarding the cost chronic diseases have on the state, including heart disease, stroke, cancer, obesity, diabetes, and binge drinking, and also received reports of successful efforts taken at the local level to address some of these chronic diseases.

The committee received information regarding efforts being taken by private health systems in the state to provide preventive health and wellness services, including:

- Patient-centered medical homes;
- Health coaches;
- Health education;
- Health professional education;
- Corporate wellness;
- Research; and
- Partnership initiatives.

Healthy North Dakota Initiative

In compliance with the committee's study charge to study the immediate needs and challenges of implementing the Healthy North Dakota initiative, the committee received a report on the status of the initiative from the Healthy North Dakota Coordinator, who is hired as a consultant to State Department of Health (DOH).

Healthy North Dakota is a statewide partnership that brings together partners and stakeholders to identify common strategies to address health issues. The initiative is organized as follows:

1. Healthy North Dakota workgroups.
2. Statewide Vision and Strategy Group:
    a. Statewide Vision and Strategy Planning Committee; and
    b. Statewide Vision and Strategy Steering Committee.

The framework of the initiative is designed to help people make healthy choices by focusing on wellness and prevention in schools, workplaces, senior centers, homes, and any place people live, learn, work, and play. The initiative is working to help identify and fill gaps in prevention efforts. The Statewide Vision and Strategy Group has developed the current state health improvement plan (SHIP) and strategic map, which includes long-term vision for initiatives up to the year 2020. The SHIP is intended to give direction to overarching clinical, public health, and integration goals and targets.

The report identified funding of the initiative as a challenge. The federal preventive health and health services block grant from the Centers for Disease Control and Prevention funds the initiative. This block grant is one of the few grants received by DOH which provides leeway to select the health issues for which to dedicate the funding. The DOH has seen a reduction in this grant amount in each of the past four years and the future status of this funding is uncertain.

Delivery Technology

The committee received testimony from representatives of Avera Health, a South Dakota company that offers telemedicine services in some North Dakota hospitals. In addition, the committee received testimony from a representative of one of the North Dakota hospitals that contracts with Avera Health for these telemedicine services.

The testimony described the health care situation in North Dakota as the perfect storm--with Medicaid Expansion, a retiring workforce, obesity and chronic condition rates, aging baby boomers, declining reimbursement for medical services, federal funding cuts, accountable care organizations, a surge in transient workers and population growth, and unmet mental health needs. Telemedicine was presented as a new and innovative health care delivery system that increases access to health care services while reducing travel, utilizes evidence-based protocols across the entire health care delivery network, allows for expanded use of nurse practitioners and physician assistants by having a physician readily available, improves safety with earlier intervention and reduction of costly transport, and provides care that is not dependent on the location of the provider, which allows for better workforce distribution. Telemedicine was presented as a way to address rural challenges as well as a way to support workforce needs.

The presentation of the Avera Health eEmergency telemedicine services indicated the eEmergency services use two-way video equipment in rural emergency rooms to link to emergency trained physicians at a central hub, 24 hours per day, seven days a week. Contracting hospitals pay a set, flat monthly fee that is based on the hospital's size, volume, and acuity of care. A representative of a contracting hospital testified that when the hospital uses eEmergency, its billing does not change.

The committee was informed possible public policy issues related to telemedicine include credentialing, technology connectivity, reimbursement, licensure, and expansion of approved services.

The committee received testimony from a representative of DocbookMD, regarding the DocbookMD application designed for use by physicians. The application is being used in 39 states and just recently became available to North Dakota physicians.

The committee received testimony from a representative of LifeLineMobile, Inc., which is a business that makes specialized vehicles called mobile units for health care delivery. The Ronald McDonald House uses one of these mobile units for the Bridging the Dental Gap program. The committee was informed there do not appear to be any state laws that negatively impact the ability of providers to use these mobile units. Over time, the improvements in technology connectivity are improving.

Emergency Room Usage

The committee received information regarding whether the state can take steps to address problems related to hospital emergency rooms being used for conditions that are not medical emergencies. The committee reviewed the requirements of the federal Emergency Medical Treatment and Labor Act (EMTALA), and how this federal law limits state action regarding the matter of hospital emergency departments. In general, EMTALA requires hospitals with emergency departments to provide a medical screening examination to an individual who comes to the emergency department and requests such an examination. The federal Emergency Medical Treatment and Labor Act prohibits hospitals with emergency departments from refusing to examine or treat an individual with an emergency medical condition.

The committee was informed hospitals with an emergency department which participate in Medicare are required under EMTALA to:

- Provide an appropriate medical screening examination to any individual who comes to the emergency department;
- Provide necessary stabilizing treatment to an individual with an emergency medical condition or an individual in labor;
- Provide for an appropriate transfer of the individual if either the individual requests the transfer or the hospital does not have the capability to provide the treatment necessary to stabilize the emergency medical condition or the capability or capacity to admit the patient; and
- Not delay examination or treatment, or both, to inquire about the individual's insurance or payment status.

The committee was informed EMTALA was implemented to prevent the "dumping" of patients who were unable to pay for services. Prior to EMTALA, a patient coming into a hospital emergency department often had no right to treatment or even evaluation, no matter how dire the medical condition. If patients could not prove that they had the resources to pay for care, they could be turned away or sent elsewhere. These individuals often suffered adverse

health consequences or death as a result of delayed care. The federal Emergency Medical Treatment and Labor Act was designed to provide protection to patients.

In investigating possible state options, the committee learned hospitals are not allowed to move individuals to off-campus facilities or departments, such as an urgent care center or satellite clinic, for a medical screening examination. In two specific situations in North Dakota the layout of the hospital made it such that patients presented to a central desk and a receptionist triaged individuals to either the emergency room or to the attached clinic. This situation was not allowed by CMS and the hospitals were required to come into compliance with EMTALA. In addition, hospitals that refer patients to a clinical setting after presenting to the emergency room but before a medical screening examination has determined no emergency medical condition exists have been found to be in violation of EMTALA.

As EMTALA relates specifically to critical access hospitals, the law requires critical access hospitals to provide emergency care on a 24-hour-a-day basis. All emergency services in a critical access hospital must be provided as a direct service. The emergency room cannot be a provider-based offsite location. An adjacent clinic used for emergency purposes does not meet this requirement. If a patient presents to the critical access hospital a medical screening examination to determine if an emergency medical condition exists must be conducted. If a patient is sent from the emergency room to an adjacent clinic prior to a medical screening examination, this would be considered a violation of EMTALA. If a medical screening examination determines an emergency medical condition does not exist, the EMTALA obligations have been met.

The committee was informed that unlike some other federal regulations, EMTALA does not include a state option to waive the requirements. A waiver may only be issued when the President has declared an emergency or disaster and the Secretary of HHS has declared a public health emergency and has exercised waiver authority.

A representative of the DOH testified it may be valuable for hospitals to review the hospitals' policies to ensure reasonable steps are being taken to increase use of walk-in clinics. The committee discussed the desire of having DOH work with the North Dakota Congressional Delegation to address the issues related to emergency room usage and the possibility of allowing emergency department referrals to walk-in clinics.

Community Health Needs Assessments

The committee received a presentation of the Center for Rural Health's summary of the most recent community health needs assessments (CHNAs) of North Dakota hospitals. Under the ACA, nonprofit hospitals are required to complete a CHNA once every three years. The summary is not required but was compiled as a service to put the data in an aggregate report. The ACA requires the hospitals to complete a CHNA, prioritize the identified needs, and develop an implementation strategy that outlines how the hospital will address some of the identified issues.

The summary of the most recent North Dakota CHNAs completed by 39 hospitals identified the 10 most frequent themes or subjects reported in the CHNAs:

Theme or Subject	Number of CHNAs Including This Theme or Subject
Health care workforce shortages	28
Obesity and physical inactivity	16
Mental health	15
Chronic disease management	12
Higher costs of health care for consumers	11
Financial viability of the hospital	10
Aging population services	9
Excessive drinking	7
Uninsured adults	6
Maintaining emergency medical services	6
Emphasis on wellness, education, and prevention	6
Access to needed equipment or facility update	6

Scope of Practice

The committee received information from medical providers regarding an opportunity to better utilize advanced practice registered nurses in the involuntary commitment proceedings process. The practitioners requested the law be amended to allow advanced practice registered nurses to practice at the full range of their scope of practice.

RECOMMENDATIONS

Legislative Management Study of North Dakota's Health Care Delivery System

The committee recommends a bill [15.0092.02000] to provide for the Legislative Management to continue its ongoing study of the needs and challenges of the North Dakota health care delivery system. The study may include monitoring the implementation of the ACA, examining Medicaid Expansion and Medicaid reform, and considering the

feasibility of developing a state-based plan for a health care model that will comply with federal health care reform in a manner that will provide high-quality access and affordable care for North Dakota citizens. The School of Medicine and Health Sciences Advisory Council would be required to make periodic reports to the Legislative Management on the status of the biennial report developed pursuant to Section 15-52-04.

Health Professional Assistance Programs Study and Report

The committee recommends a bill [15.0301.02000] to direct DOH during the 2015-16 interim to evaluate state programs to assist health professionals, including behavioral health professionals, with a focus on state loan repayment programs for health professionals. During the 2015-16 interim DOH shall make periodic reports to the Legislative Management on the outcome of the study, including presentation of recommended legislation.

Medicaid and Medicaid Expansion Cost-Sharing Study and Report

The committee recommends a bill [15.0345.01000] to direct DHS during the 2015-16 interim to study options for implementing income-based cost-sharing provisions for the Medicaid and Medicaid Expansion programs. This study must include consideration of provider recovery rates for copayments, information technology capacity for implementing income-based cost-sharing provisions, consideration of how income-based cost-sharing has been implemented by other states, analysis of the costs and benefits of cost-sharing, and consideration of whether cost-sharing improves the effectiveness of Medicaid and Medicaid Expansion programs. Before July 1, 2016, DHS would be required to report to the Legislative Management the outcome of the study and the associated legislative recommendations and related draft legislation.

Telemedicine

The committee recommends a bill [15.0079.02000] to provide that the PERS uniform group insurance must provide medical benefits coverage under a policy that provides coverage for health care services provided by a health care provider or health care facility by means of telemedicine which are the same as the policy coverage of in-person health care services provided by a health care provider or health care facility. The mandate is limited to the PERS system, the mandate expires in two years, the bill directs PERS to study the impact of the bill during that two-year period, and the bill directs PERS to introduce to the 65th Legislative Assembly a bill to extend the mandate of coverage to the private health insurance market.

Substance Abuse Treatment

The committee recommends a bill [15.0304.01000] to amend the group health policy mandate for substance abuse coverage. The bill applies the substance abuse coverage requirements to all health insurance policies, removes the coverage requirement formulas for different types of substance abuse services, and clarifies that required coverage must include inpatient treatment, treatment by partial hospitalization, residential treatment, and outpatient treatment.

Involuntary Commitment Proceedings

The committee recommends a bill [15.0133.01000] to provide for revision of the involuntary commitment proceeding law to update the language and to expand the statutory authority of advanced practice registered nurses to authorize advanced practice registered nurses to act as independent expert examiners in involuntary commitment proceedings.

Medicaid Expansion Contracts

The committee recommends a bill [15.0303.01000] to amend the Medicaid Expansion law to provide if DHS implements the Medicaid Expansion program through a contract with a private carrier, the department shall issue one RFP for the health insurance component of Medicaid Expansion and shall issue one RFP for the pharmacy benefit management component of the Medicaid Expansion or shall provide the pharmacy benefit management services through DHS. The bill provides if the pharmacy benefit management component is not provided through DHS, the contract between the department and the pharmacy benefit manager must include specified provisions that address passthrough pricing, transparency, and audit provisions.